



The Commission on Rationalizing Health Care Resources ***NJHA's Initial Response***

Gov. Corzine formed the Governor's Commission on Rationalizing Health Care Resources in October 2006. Its charge: "to evaluate the economics of the acute care hospital sector in New Jersey and provide recommendations to the Governor on how hospitals should be supported in the future in response to financial distress." After months of hearing testimony, gathering information and studying data, the Commission concluded that its efforts "clearly and unambiguously show that many hospitals in the state are in poor financial condition and a wave of more closures appear likely."

The Commission's report provides a thorough explanation of the many factors that have pushed the state's hospitals to the cusp of crisis, as evidenced by the rash of hospital closures and bankruptcies in recent years. Those contributing factors include chronic underfunding of the state's charity care program, inadequate reimbursement from Medicaid and Medicare, a proliferation of ambulatory care facilities that hold an uneven competitive advantage over hospitals and physician practice patterns that reveal a level of care much higher than the rest of the nation.

But while the report does a fine job of explaining how New Jersey's hospitals arrived at their precarious state, it falls short in addressing the most fundamental problem confronting our state's hospitals: inadequate reimbursement, especially from governmental payers. The Commission's recommendations provide some steps for stopgap or incremental relief, but New Jersey's healthcare crisis is beyond the point of incremental action.

Each of the many recommendations posed by the Commission could be accomplished, and our hospitals would still be struggling. The somber reality is that 18 New Jersey hospitals have closed since 1992 – five, in fact, have closed just since the Commission was created. Half of the state's hospitals are losing money, five have filed for bankruptcy protection in the last 18 months, and several others are seeking buyers in a desperate effort to remain open. Access to healthcare isn't the only casualty for our state when a hospital closes; the loss of jobs is also mounting, with more than 6,500 hospital jobs lost in the last five years.

We do not mean to diminish the Commission's work. There is much to digest in this report, and NJHA continues to review it. The Commission has provided a thoughtful and candid explanation of the factors leading to hospitals' financial distress, along with a

number of sound recommendations. We thought it right that our initial response be equally forthcoming and candid.

Specifically, we believe the state needs to give additional consideration to several key needs that are not addressed in the Commission's report. They are:

- The undeniable need for sufficient charity care funding – *new funding*, not just shifting existing dollars – at a level that does not cripple the hospitals that care for our state's poor and uninsured. This funding must remain adequate as the state continues its efforts to shift more New Jerseyans to the insurance rolls.
- A long overdue infusion of funding into the Medicaid program, especially for physician reimbursement. New Jersey's woeful underfunding of this program has numerous ramifications in patient access to care, overburdened Emergency Departments and the overall fiscal health of hospitals.
- The need to examine hospitals within the context of the entire continuum of healthcare services. Any plan for the future of healthcare in our state is incomplete unless it recognizes the role of not only hospitals, but also federally qualified health centers, ambulatory care facilities, long term care, home health, assisted living and other types of providers.

The Commission's Report: Where We Agree

The Financial Plight of New Jersey Hospitals

The Commission unflinchingly acknowledges the critical nature of the fiscal crisis gripping New Jersey's hospitals. "The most important conclusion to emerge from the Commission's work is that New Jersey hospitals are truly in poor financial health.... Based on the current financial picture, the residents of New Jersey should expect a wave of additional hospitals that will face financial distress in the next few years." (pgs. 17, 27) The Commission notes throughout its report that New Jersey hospitals lie below the national average on a number of key financial indicators including operating margin, total margin and days cash on hand. Meanwhile, the average age of plant for New Jersey hospitals is 30 percent higher than the national average. Specifically, in 2005 the average median plant age was 13.4 years for New Jersey's hospitals, which was 30 percent higher than the 10.2 average median value at the national level. (pg. 73)

Operating Margins

The report recognizes New Jersey hospitals' razor-thin operating margins. It states: "The trend since 2002 has been negative, with operating margins for New Jersey hospitals declining steadily since 2002. Audited data for 2006 show a median operating margin of positive .02 percent, indicating that approximately half of the State's hospitals lost money from operations.... By way of comparison, the average operating margin for acute care hospitals in the entire nation is approximately 3.3 percent." (pg. 66)

Charity Care Underfunding

Throughout the Commission's Report, the gross underfunding of charity care is illustrated along with its negative impact on the hospital industry. "The charity care program, like Medicaid, pays hospitals less than the full cost of care. The program is thus another example where state government pays less than full costs – hospitals and other payers are expected to make up the difference." (pg. 112) The report goes on to state: "New Jersey, like other states, continues to rely on the goodwill and professional and legal obligations of hospitals and doctors ... to provide such care." (pg. 112)

NJHA applauds the Commission's recognition of this broken system and the need for wholesale change to ensure proper funding for hospitals.

Inadequate Medicaid Rates

The report also emphasizes the woefully inadequate Medicaid rates for New Jersey's providers, particularly physicians. The document states: "Public funding for health care has two important goals. First, it should provide adequate financing to ensure equitable access to health care for all people. Second, public funds should support health care institutions (i.e. hospitals) that serve a high fraction of individuals from vulnerable populations (i.e. essential hospitals). The current public financing system for healthcare in New Jersey falls short on both goals. Medicaid payments are woefully inadequate such that access is compromised, particularly for physician services. And while the State provides important charity care payments to hospitals, it has not settled on whether it is an insurance program for low-income patients or a grant program for safety net hospitals." (pg. 112)

Other states are not immune to government underfunding of healthcare programs, but the Commission states that the situation in New Jersey "appears to be more pronounced here with respect to payment levels." (pg. 107) It goes on to declare that "the abysmally low reimbursement rates have severely impacted the availability of healthcare professionals who are willing and/or financially able to offer services to Medicaid patients." (pg. 151)

The report recommends that Medicaid reimbursement rates should be set to a minimum of 75 percent of Medicare rates, with a goal of encouraging more physicians to provide care for Medicaid patients, thus improving healthcare access. However, it must be noted that a minimum payment rate of 75 percent would be a cut to hospitals that currently receive a Medicaid payment rate of 79 percent of Medicare rates. (pg. 151) Specifically, Medicaid currently pays hospitals 69 percent of their costs, on average. Medicare pays hospitals 89 percent of their costs. The recommended Medicaid rate of 75 percent of Medicare rates would place hospitals' reimbursement at roughly 67 – a slight reduction versus the current 69 percent.

Glaringly absent in the Medicaid discussion is any reference to Medicaid managed care. Medicaid managed care reimbursement to providers can be abysmally low – the leading cause in the low participation of physicians and specialists in the managed care program.

In addition, the state must ensure that its Medicaid managed care plan has an adequate network and providers that accept all patients within the plan. New Jersey's existing system, unfortunately, is full of "phantom networks" that exist on paper only. The state Department of Human Services has no mechanism to monitor the network to ensure that providers are accepting patients. The access problems posed by these phantom networks drive more patients to hospital Emergency Departments.

Cost Shift

The Commission's report provides a clear and thorough explanation of the "hydraulic fiscal cost shift" that is created by government payers' gross underfunding of hospitals. It describes the vicious cycle this way: "Under the system, some payers pay sizeable mark-ups over full costs for the services used by their insured. Government, on the other hand, often chooses to pay less than full cost. The uninsured, although initially charged the highest prices by hospitals, in the end pay much less than the full cost of their services. The system requires the managers of hospitals to recover the payment shortfalls forced on them by the uninsured, by Medicare and by Medicaid." (pg. 101)

It should be noted, however, that in the report's graphic representation of the hydraulic cost shift (pgs. 101, 102), it erroneously omits charity care as a major payer, identifying only self pay as the "usually uninsured."

Physician/Hospital Relationships

NJHA applauds the Commission's analysis of the unique relationship between hospitals and their physicians. The recommendations to provide for better alignment of incentives, greater physician accountability and transparency are welcomed.

The suggestion of greater transparency for physician practices and hospitals is also welcome, but any quality data should be consistent with the work of organizations such as The Joint Commission, the Centers for Medicare and Medicaid Services and the National Quality Forum.

The recommendation for a software program that monitors physician orders is an intriguing one clearly aimed at addressing the practice pattern issues in our state, particularly for patients at the end of life. NJHA appreciates the Commission's recognition of this problem, but worries that this software could become another expensive mandate on hospitals that already are struggling, as the report so clearly states.

Greater Accountability for Ambulatory Surgery Centers

A key finding of the Commission's report is the inconsistent nature of state licensing standards and their impact on the proliferation of ambulatory surgery centers, or ASCs. According to the report, there are 181 Medicare-certified ASCs in New Jersey, yet only

95 are licensed. The Commission notes that “these uneven licensing standards are largely without basis and should be evenly applied across all facilities providing similar services.” (pg. 121) The report goes on to state that “the lack of uniform regulations and reporting of quality and performance data is a major impediment to understanding their actual impact on the health care system or the quality of care. Any rational policymaking needs to include more robust data reporting requirements on the part of these facilities with respect to quality and cost and apply uniform regulations based on the services provided rather than the specific venue as is the case with the current exemption for single operating room surgical practices.” (pg. 121)

NJHA supports the Commission’s recommendations that call for licensing standards that apply to all ambulatory care surgical centers and require reporting on quality outcomes, among other reporting requirements. While it levels the playing field between hospital-based ambulatory surgical centers and non-hospital based centers, it also provides valuable and essential information to consumers, allowing them to make educated choices regarding where they will receive healthcare services. Furthermore, ASCs should also be covered by provisions of the Patient Safety Act (similar to hospitals), which requires the establishment of a patient safety committee and the reporting of adverse events. ASCs also should be required to report certain infection rates on par with hospital reporting.

Overuse of Hospital Emergency Departments

NJHA applauds the Commission’s discussion of the overutilization of hospital Emergency Departments, affirming the “false belief that emergency rooms can substitute for reliable and regular medical care.” (pg. 149)

While many hospitals have tried to alleviate overcrowding with some sort of fast-track system in their ED (depending on space and resources), patients cannot be turned away from the ED, even when their condition is not emergent. That’s part of hospitals’ mission, and it’s also federal law. Alternative resources exist in our state’s federally qualified health centers, however many of these facilities are not open 24 hours a day, 7 days a week, unlike a hospital ED. Furthermore, FQHCs often charge co-pays, while EDs do not. In addition, many patients report that transportation to FQHCs, as well as a lack of specialists on site, present additional problems.

An additional contributing factor to the overuse/overcrowding of hospital EDs is the increased prevalence of behavioral health patients that are presenting in the ED. These patients all too often become “stranded” in the ED for an extended period of time because the state has not established sufficient capacity in more appropriate settings. NJHA supports the commission’s recommendation that “state health policy should expand mental health and substance abuse capacity in the community, prioritize funding for mental health and substance abuse services, and insist on tailoring services to patients’ wellness and recovery needs.” (pg. 151) Specifically, state intervention in improved screening capabilities and increased short term care facility (adult crisis) beds is vital.

Certificate of Need

NJHA agrees with the Commission's finding that the deregulation of Certificate of Need (CN) resulted in unintended consequences that have led to an oversupply of some services and a scarcity of others. While deregulation was introduced to be responsive to a new competitive healthcare marketplace, it was anticipated that hospitals would compete with each other, not with ambulatory care centers.

NJHA applauds the Commission for recognizing that CN requirements should be subject to a regular review. For example, need methodologies for services that remain under Certificate of Need have not been updated in years, with the exception of home health which is only now being reviewed after more than 15 years. Rational decision-making for the addition of new services is impossible without current data and methodologies that can accurately assess need. And finally, the CN review processes that fall under Full Review and the Architectural review are so long that it can take an applicant at least a year to establish just an ambulatory care facility. Such a timeframe is simply unresponsive to the competitive marketplace in healthcare.

Regarding the CN process for closing a hospital, NJHA supports the Commission's recommendation that the CN hospital closure review process should be "streamlined and refocused" to provide "assistance in planning and executing orderly closure instead of reviewing the need for closure" (*pg. 176*), which will ensure that the appropriate support is available in the planning and execution of an orderly closure rather than making the determination if a hospital can or cannot close. Hospital boards that make the decision to close do not do so lightly, and NJHA applauds the recommendation for a more streamlined process.

Transparency

A consistent theme throughout the report is a call for greater transparency of quality data, pricing information and other healthcare information of interest to the public. NJHA shares the Commission's commitment to transparency. New Jersey hospitals participate in a number of quality reporting efforts led by DHSS, the Centers for Medicare and Medicaid Services, The Joint Commission and others. NJHA shares both quality data and pricing information with the public via its Web sites, www.njhospitalcarecompare.com and www.njhospitalpricecompare.com.

But we would be remiss if we did not stress two critical considerations in the transparency discussion. One, transparency must be applied evenly across the healthcare system, applying not only hospitals, but also insurers and other payers, physicians, ambulatory care centers and other providers. And two, in some instances, the public is better served when reporting is done in a confidential manner. A prime example is the state's annual Patient Safety Report, which provides aggregate information on the preventable adverse events that occur in hospitals. This initiative provides an invaluable trove of information to help hospitals and state health officials identify problem areas and develop best practices that make care safer for all patients. And it is accomplished by

allowing the reporting to occur in a confidential and non-punitive environment. Without it, there would be a chilling effect on reporting, and ongoing efforts to identify safety improvements would be jeopardized.

Where We Disagree

Bed Capacity

The Commission has suggested that New Jersey is over-bedded, stating “analyses of the demand for hospital services indicate that there is currently a surplus of beds in every hospital market area and without reduction in the supply of hospital beds, estimated bed surplus will continue in many hospital market areas through 2010 and 2015.” (pg. 50) The Commission goes on to state that considering the state’s need for surge capacity is beyond its scope of work. (Pg. 49) However, both federal and state agencies have instructed hospitals to ensure adequate surge capacity to respond to a natural or man-made disaster. In fact, federal agencies distributing funding through states are *requiring* hospitals to establish surge capacity to be eligible for funding. To ensure consistency with goals established by the U.S. Department of Health and Human Services, the state Department of Health and Senior Services has established strengthening medical surge capacity as a priority for funding within defined public health regions.

Given the Commission’s recommendations to reduce capacity, hospitals will face conflicts and government contradictions when determining if surge capacity should be increased to be eligible for federal emergency preparedness funding.

Expanded Operations

A key recommendation in the report is to expand a range of services within hospitals to optimize utilization of physical plant and human resources on a 365-day basis. (pg. 125) This recommendation poses significant concern when considering the majority of the Commission’s report is centered on the poor financial state of New Jersey’s hospitals. It is unclear how hospitals would be expected to expand services given the woefully inadequate reimbursement from payers. Furthermore, it is the physicians that ultimately offer direct patient services, and it remains unclear whether such a plan would gain support among the physician community, especially since the states does not reimburse physicians for their charity care services. The recommendation also fails to recognize the growing shortage of professional staff such as intensivists and nurses.

The report goes on to state that “many hospitals can no longer enforce ED service call obligations on physicians, and in a growing trend, must pay significant fees to physicians in order to secure urgently needed and essential coverage,” (pg. 125) further illustrating the potential difficulty of expanded services.

Closure Costs

A large portion of Chapter 14 deals with the cost of a hospital's closure. These expenses include debt resolution, employee severance and other costs. While it is appropriate that a significant analysis is offered to addressing these costs, NJHA questions the recommendation that hospitals in a closed hospital's market areas might pay for a generous severance program. This is contradictory to another finding in the report which points out that 60 percent of the troubled hospitals in the state come from just two markets. The reality is that neighboring hospitals are very likely to be in similar financial straits and can offer no resources to support this recommendation.

Staffing

The report's recommendation to implement an intensivist model in the hospital ICU (*pgs. 126, 127*) presumes an availability of such professionals and fails to acknowledge the shortage of intensivists facing the industry.

Furthermore, the report fails to address the existing and projected shortage of nurses in the state. The Center for Nursing at Rutgers University projects that New Jersey's nurse vacancy rate will reach approximately 40 percent by 2020, as practicing nurses retire. The average age of a nurse in New Jersey now stands at 54, higher than the U.S. average. The shortages are particularly acute in the ICU, OR and ED. Hospitals cannot increase the supply of nurses on their own; the leading factor in the shortage of nurses is the scarcity of nurse faculty. Each year, in New Jersey and nationwide, qualified nursing school candidates are turned away because of a lack of training slots.

Coordination of Care

Any attempt to address the issue of coordination of care must examine the full continuum of care, not just hospitals, physicians and patients. The issue is how an individual navigates or progresses through the system and has access to all services within the healthcare continuum, including primary care, home health, long term care and rehabilitation, among other services. Coordination can be challenging for the fully insured but is compounded when those receiving Medicaid or charity care cannot access many of the services. The result is a lack of coordination of care that contributes to a vicious cycle of emergency room usage. In addition, patients often remain in hospital beds much longer than necessary due to inadequate post-acute care services for the charity care and Medicaid populations.

Medicaid managed care, offered in collaboration with the state's Department of Human Services, is charged with ensuring that care for beneficiaries is managed. To meet this objective, however, a Medicaid managed care plan must have an adequate network and providers that accept all patients within the plan. Unfortunately this is not the case in New Jersey. On paper these plans may be able to demonstrate an adequate network of physicians, but in reality the system is beset with "phantom networks" that exist on paper only. DHS has no mechanism to monitor the network to ensure that providers are

accepting patients, while providers continue to receive monthly premiums for the services they are charged with providing.

Until hospitals have the ability to place patients following an acute care stay, patients will remain in the hospital much longer than necessary. Hospitals, in turn, will be denied reimbursement by the very companies that fail to meet their responsibility to ensure a network of post-acute care providers that will accept their subscribers. The result is longer lengths of stay, unreimbursed costs and the perception that hospitals are inefficient.

Trustee Relationships

The Commission makes a number of recommendations regarding a hospital's relationship with its Board of Trustees. It states that "a majority of hospitals are nonprofit institutions (and) many of these respective institutions have not generally kept pace with changes in best practices for governance despite the increasing complexity and scope of health care institutions." (pg. 58)

In a survey of NJHA members and an analysis of its board database, NJHA found that New Jersey hospitals have made significant strides in changing their governance policies since 1997. While in 1997 there were a majority of institutions without term limits, most have revised their bylaws to implement term limits; where once there were boards that carried 40 to 50 members, the majority now recommend a more manageable 13 to 19 members. Education programs are offered at the start of many board meetings, and trustees often attend other venues for continuing education, paid for by the hospital.

With the passage of New Jersey's trustee education act (Chapter 74 P.L. 1971, c. 136) more trustees will have a foundation for better governance. Combined with voluntary continuing education, today's trustees are better prepared than ever to master the complex role they have within the healthcare field.

The best practices recommended by the Commission are standard to any strong nonprofit institution. Most boards in the state strive to meet these standards already. The recommendations on board size and term limits have been implemented by the majority of hospitals in the state, and NJHA continues to work with hospital boards across the state offering education, assessment, facilitation, best practices, orientation and more. NJHA also is developing a certificate program for individual trustee as well as for the full board.

In specific areas of concern, NJHA notes that the recommendation of a three-year absence from service would deny an institution the knowledge and expertise of a seasoned trustee. Furthermore, the addition of employees to the board is contraindicated by the conflict of interest policies the Commission recommends.

Areas In Need of Further Detail

Hospital Essentiality

A cornerstone of the Commission's report is determining what hospitals are essential and therefore deserving of financial relief if needed. This approach raises a number of concerns and would require further explanation to determine if the industry could support it.

In particular:

The report suggests that "each hospital was placed in one of the four quadrants on the framework grid" for evaluating hospitals' financial viability and essentiality. (pg. 159) The report then suggests that this framework "has been designed to be 'dynamic' in that it can be repeated over time with updated data." (pg. 160)

The report lists trauma center designation as the only metric for assessing a hospital's "provision of essential services." (pg. 161) Certainly trauma center services are highly essential, but there may be additional services such as oncology, cardiac surgery, obstetrics, etc., that should be considered when determining "essentiality."

Again, when considering the grid, three-quarters of the hospitals have been placed in quadrants where they would not stand to receive state assistance, even though half are losing money. The report concludes that 38 out of 80 hospitals are below the financial viability average. Sixty percent of these are in just two markets. (pg. 163) This would suggest that many of our state's distressed hospitals will be left to languish, which is of great concern.

Distribution of Charity Care Subsidy Payments/ Distressed Hospitals

The Commission suggests that "one way for the State to support essential, financially troubled hospitals is to revamp the way charity care subsidy payments are distributed." (pg. 168) These criteria will need to be analyzed to determine their full impact on hospitals; the obvious concern is that this recommendation would undermine the financial viability of numerous hospitals, including those that are profitable but only marginally.

In addition, this recommendation seems to signal a fundamental change in the charity care principle. By design – if not in actual application – charity care reimbursement is supposed to follow the patient, with dollars reimbursed to hospitals that provide the care.

The Commission report also discusses the establishment of a Distressed Hospital Program to assist financially distressed, essential hospitals. "Even with the benefit from closure of some hospitals and increased Medicaid and charity care as recommended in the previous section, state funding support will likely be necessary to help some or all essential, financially troubled hospitals improve their financial conditions." (pg. 168)

While NJHA supports funding for distressed hospitals, we're not convinced that the revenue source identified in the report (an added assessment on ambulatory facilities) is appropriate and, if enacted, would further alienate New Jersey's physician community.

Furthermore, to qualify for this support, hospitals must meet a significant number of criteria that may prove to be too prescriptive. (*pg. 169*) The report lists 14 different criteria and states that a hospital deserving of relief must satisfy all of the metrics. It is unclear following a preliminary analysis whether any hospital in the state would in fact qualify as deserving.

Early Warning Triggers

The Commission emphasizes the need for an early warning system – data triggers that will alert the state when a hospital is entering financial distress. That's certainly important knowledge, but the information needed already exists. DHSS has access to the data through the state's Health Care Facilities Financing Authority, and NJHA also maintains financial data that is used to monitor hospitals' financial health. The issue is not so much the need for this warning data, but rather, how will the new system change the way the state responds?

Future of Non-Essential, Non-Viable Hospitals

This issue is one that is at the heart of the Commission's work: Should non-essential, non-viable hospitals be allowed to fall victim to the marketplace and close? There is no easy answer.

Certainly we will see more hospital closures in our state. Sometimes closing a facility is the most prudent choice. But NJHA's worry throughout this firestorm of closures is that the wrong hospitals will close, for the wrong reasons, and that ultimately our state will face a new crisis – an access-to-care crisis. The Commission's quadrant approach of classifying hospitals as “essential” or not, “viable” or not, attempts to impart some planning and oversight to this rash of hospital closures. NJHA urges caution that this criteria not be applied too constrictively, leaving too many of our state's hospitals vulnerable to the harsh New Jersey marketplace.

Consolidation/Diversion of Hospital Relief Subsidy and GME

The Commission's report recommends consolidating the Hospital Relief Subsidy Fund and graduate medical education into Medicaid direct payments to provide a uniform reimbursement methodology based on Medicaid volume versus fragment formulas. (*pg. 113*) Analysis must be conducted to determine the direct impact this would have on diverting revenue away from the charity care pool and the impact on teaching hospitals that would no longer receive GME.

Similarly, the report's recommendation to shift some HRSF payments to the HRSF for mental health to increase bed capacity and relieve the burden currently facing hospital

ERs is admirable, but again analysis needs to be conducted to determine the effect such a siphoning of funds would have on the charity care funding pool. (*pg. 113*)

But most importantly, this recommendation fails to address the much larger problem of inadequate funding. Shifting and consolidating existing funds will not ease the crisis gripping hospitals today.